DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

February 27, 2004

Report Number: A-04-03-06007

Mr. James D. Boyd
Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Dear Mr. Boyd:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's final report entitled "*Nursing Homes and Denial of Payment Remedies in the State of Florida*" for the period October 1, 1999 to September 30, 2001. This audit was initiated due to the general public concern with nursing home issues. Our primary focus was the measures for enforcing nursing home compliance with quality of care standards for Medicaid recipients. A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

The objectives of our audit were to evaluate whether State controls were adequate to prevent improper Medicaid payments to nursing homes under the denial of payment remedy; and to ensure the mandatory denial of payment remedy for substandard quality of care was applied in nursing homes that were not in substantial compliance with the prescribed Medicaid participation requirements.

Title XIX, section 1919 of the Social Security Act established the requirements for nursing facilities, which are implemented by the State and Secretary of HHS. As part of these requirements, nursing facilities undergo an annual State survey and certification process to reveal whether a nursing facility is in substantial compliance with the Federal requirements. The 42 CFR § 488 sets forth the regulations governing the survey, certification, and enforcement process. Denial of payment is an enforcement remedy for nursing facilities not in substantial compliance with one or more of the Medicaid participation requirements.

The State permitted improper Medicaid payments for new admissions to sanctioned nursing homes. We found that State controls were not adequate to prevent improper Medicaid payments to sanctioned nursing homes. From 100 sanctioned nursing homes, there were 77 nursing homes receiving Medicaid payments while under the denial of payment sanction. Of these 77 nursing homes, 31 had unallowable Medicaid payments totaling $176,853 with $99,957 in Federal financial participation[1].

[1] The Federal financial participation rate used was 56.52 percent, the lowest of the rates in effect during the 3-year period (fiscal years 2000 through 2001).

However, State controls for ensuring the mandatory denial of payment remedy for substandard quality of care in nursing homes were correctly applied and adequate. As a result, only 21 of the 547 nursing homes surveyed by the State (4 percent) warranted the denial of payment remedy based on the mandatory denial of payment for new Medicaid admissions requirements. The State was in substantial compliance with Medicaid participation requirements and did prescribe the denial of payment remedy as directed by law.

We recommend the State:

- refund to Centers for Medicare & Medicaid Services $99,957 representing the Federal share of the $176,853 in unallowable payments; and

- implement additional procedures to ensure payments to the provider(s) are suspended timely.

In written comments, the State did not agree with our amount of unallowable payments, but did concur with our recommendation to implement additional procedures and agreed to take corrective actions. The State's comments are included as Appendix B to our report.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), Office of Inspector General reports are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR Part 5).

If you have any questions or comments about this report, please do not hesitate to call me or your staff may call Mary Ann Moreno, Audit Manager, at (305) 536-5309, extension 24 or through e-mail at mmoreno@oig.hhs.gov. To facilitate identification, please refer to report number A-04-03-06007 in all correspondence relating to this report.

Sincerely

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures - as stated

Direct Reply to HHS Action Official:

Renard Murray
Associate Regional Administrator
Centers for Medicare & Medicaid Services, Region IV
Division of Medicaid and State Operations
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING HOMES AND DENIAL OF PAYMENT REMEDIES IN THE STATE OF FLORIDA

FEBRUARY 2004
A-04-03-06007

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This audit was initiated due to the general public concern with nursing home issues. Our primary focus was with the measures for enforcing nursing home compliance with quality of care standards for Medicaid beneficiaries.

Due to widespread need for nursing home reform, Congress passed the Omnibus Budget Reconciliation Act of 1987. This legislation included the Nursing Home Reform Act, which ensured residents received quality care in nursing homes through the establishment of a Residents' Bill of Rights and the provision of certain services to each resident. It also required nursing homes participating in the Medicaid and Medicare programs to comply with the requirements for standards of care as prescribed by Federal laws.

Title XIX, section 1919 of the Social Security Act established these requirements for nursing facilities, which are implemented by the State and the Secretary of the United States Department of Health and Human Services (HHS). As part of these requirements, nursing facilities undergo an annual State survey and certification process to reveal whether a nursing facility is in substantial compliance with the Federal requirements.

OBJECTIVES

The audit objectives were to evaluate whether State controls were adequate to:

- prevent improper Medicaid payments to nursing homes under the denial of payment remedy; and

- ensure the mandatory denial of payment remedy for substandard quality of care was applied in nursing homes that were not in substantial compliance with the prescribed Medicaid participation requirements.

Our audit included denial of payment sanctions, which were in effect or should have been in effect from October 1, 1999 to September 30, 2001. The audit also included survey information from the Centers for Medicare & Medicaid Services (CMS) Online Survey, Certification, and Reporting database from 1999 to 2003 of all nursing homes surveyed by the State.

FINDINGS

Improper Medicaid Payments to Sanctioned Nursing Homes

The State permitted improper Medicaid payments for new admissions to sanctioned nursing homes. We found that 77 of the 100 sanctioned nursing homes received Medicaid payments while under the denial of payment sanction. Of these nursing homes, 31 had unallowable

Medicaid payments totaling $176,853 with $99,957 in Federal financial participation[1]. These improper Medicaid payments occurred because of the lack of controls between the State's Medicaid Agency and fiscal agent. Therefore, the State controls were not adequate to prevent improper Medicaid payments to sanctioned nursing homes as required in Title XIX, section 1919 of the Social Security Act and 42 CFR § 488.

Controls to Ensure Sanctions Were Applied to Nursing Homes

State controls for ensuring the mandatory denial of payment remedy for substandard quality of care in nursing homes were applied correctly and were adequate. Thus, the State has properly applied the remedy for sanctioning nursing homes that are out of compliance.

RECOMMENDATIONS

We recommend that the State:

- refund to CMS $99,957 representing the Federal share of the $176,853 in unallowable payments; and

- implement additional procedures to ensure payments to the provider(s) are suspended timely.

AUDITEE COMMENTS

The State agreed that $135,394 of the $176,853 ($99,957 Federal share) recommended for adjustment was unallowable and requested additional documentation to support the disallowance of $46,400 for which they had no record of a denial of payment for new admissions being issued. The State did not agree that the remaining $41,459 was for unallowable payments. The State responded that the disallowed payments identified in the audit included $40,262 in payments for beneficiaries who were not new admissions and $1,197 for beneficiaries whose Medicaid applications were pending approval prior to the denial of payment for new admissions sanction.

The State concurred with our recommendation for the implementation of additional procedures. The State has a recoupment process that is based upon CMS notification. Payments are researched to determine if it is deemed allowable, if not then recoupment is pursued. The State also has modified their nursing home coverage handbook.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to the State's request for documentation for the $46,400 unallowable Medicaid payments, we will provide the applicable CMS denial of payment for new admissions letters.

[1] The Federal financial participation rate used was 56.52 percent, the lowest of the rates in effect during the 3-year period (fiscal years 2000 through 2001).

In regard to the $41,459 the State believes to be allowable, we disagree that the beneficiaries were not new admissions during sanction periods. Our finding is based on admission documentation obtained from the nursing homes.

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INTRODUCTION

BACKGROUND

Nursing Home Reform Act Requirements

Congress passed the Omnibus Budget Reconciliation Act of 1987, which included the Nursing Home Reform Act that established the Residents' Bill of Rights and the provision of certain services to each resident. The Nursing Home Reform Act ensured residents received quality care in nursing homes. It also required nursing homes participating in the Medicaid and Medicare programs to comply with the requirements for standards of care as prescribed by Federal laws.

State Survey/Certification Process and Definitions

Title XIX, section 1919 of the Social Security Act established these requirements for nursing facilities, which are implemented by the State and the Secretary of HHS. As part of these requirements, nursing facilities undergo an annual State survey and certification process to reveal whether a nursing facility is in substantial compliance with the Federal requirements. Substantial compliance means a level of compliance such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Deficiencies result from noncompliance or substandard quality of care in the nursing home. Facilities not in substantial compliance with these Federal standards of care are deficient and may have enforcement remedies imposed on them. Denial of payment sanctions may be imposed alone or in combination with other remedies when certification standards of care are not met.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to evaluate whether State controls were adequate to prevent improper Medicaid payments to nursing homes under the denial of payment remedy and to ensure the mandatory denial of payment remedy for substandard quality of care was applied in nursing homes that were not in compliance with the prescribed Medicaid participation requirements. This review included denial of payment sanctions, which were in effect or should have been in effect from October 1, 1999 to September 30, 2001. The audit also included survey information from CMS's Online Survey, Certification, and Reporting database from 1999 to 2003 of all nursing homes surveyed by the State.

Scope

We obtained information from the CMS regional office, State agencies, and selected nursing homes as applicable. Data obtained included, but was not limited to:

- Medicaid paid claims information;
- nursing home admission census reports;

- billing documentation;
- nursing home Medicaid cost reports;
- denial of payment letters;
- list of noncompliant nursing facilities;
- State nursing home surveys;
- inspection reports; and
- other support documentation as applicable.

Our review was conducted in accordance with generally accepted government auditing standards. Our review was limited in scope. It was not intended to be a full-scale internal control assessment of the Medicaid agency operations. The objectives of our audit did not require an understanding or assessment of the overall internal control structure of the agency.

Methodology

For the first objective, we obtained a file containing all sanctioned nursing facilities under the denial of payment remedies from the State and reconciled this information with CMS's Long Term Care Denial of Payment Report. We then obtained the Medicaid paid claims from the Florida Medicaid Management Information System to determine if improper payments were made by the State to sanctioned nursing homes during our audit period of October 1, 1999 to September 30, 2001. We quantified these improper payments made by the State and any impact on the future reimbursement rates.

For the second objective, we verified that State controls for ensuring that all nursing homes surveyed with deficiencies were properly sanctioned for the mandatory denial of payment were adequate. We obtained the Online Survey, Certification, and Reporting database of all Florida nursing homes from CMS. This report contained the four most recent standard surveys of each nursing home entered into the database by the State survey agency. The report documented whether the State followed the guidelines for mandatory denial of payment for new Medicaid admissions by the compliance dates and the number of times a nursing facility was sanctioned. We determined if any of the nursing homes that received substantial compliance by the State should have been sanctioned.

Denial of Payment for Sanctioned Nursing Homes

To perform our review we obtained a listing of sanctioned nursing homes within the audit period from the State and CMS, including any surveys conducted solely by CMS. The reconciliation of both lists was used to determine the total number of sanctioned nursing homes in Florida. It was determined that 100 nursing homes were sanctioned with the denial of payment remedy. The reconciled list of sanctioned nursing homes was matched against the Florida Medicaid Management Information System to identify the nursing homes billing for Medicaid services during the audit period. Of the 100 sanctioned nursing homes, there were 77 nursing homes receiving Medicaid payment.

We verified the payments for new Medicaid admissions (for the denial of payment for new Medicaid admissions remedy) by reviewing admission records and billing histories for the

sanction period through visits to the nursing homes. We determined whether each payment for admissions during the sanction period was allowable or unallowable, based on the State Operations Manual, Publication 7. Our results were summarized in the following manner:

1) *Allowable* - resident was not a new admit when the nursing home was under the denial of payment remedy. The payment made to the nursing home was appropriate.
2) *Unallowable* - resident was a new admit while the nursing home was under the denial of payment remedy or the denial of payment for all Medicaid residents remedy. The portion of the payment made to the facility during the sanction was inappropriate.

For the denial of payment on all payments for Medicaid residents' remedy, billing documentation during the sanctioned period was requested. The portion of the claim paid during the sanction period was deemed unallowable. The State did not have any denial of payment on all payments for Medicaid residents.

Deficient Nursing Homes Not Sanctioned

To perform this section of our review, we requested from CMS a "Tag Report" from the Online Survey, Certification, and Reporting database for Florida's nursing homes and the F-tags, or deficiencies associated with the mandatory denial of payment for new Medicaid admissions. The "Tag Report" incorporated data from the Online Survey, Certification, and Reporting database, which contained the four most recent standard surveys of each Florida nursing home entered by the State survey agency. It listed the deficiencies, or F-tags, for each nursing home surveyed along with the survey date and compliance date for each deficiency.

Our Advanced Audit Techniques Staff performed two separate matches based on the mandatory denial of payment for new Medicaid admissions criteria:

- any deficiencies for which the nursing home is not in substantial compliance 3 months after the last day of the survey identifying the deficiencies; and
- substandard quality of care deficiencies reported on the last three standard surveys.

The first match incorporated the reconciled list of sanctioned nursing homes with the "Tag Report" identifying the nursing homes not sanctioned. The second match filtered the "Tag Report" to include only the substandard quality of care deficiencies. From these matches, it was determined whether there were nursing homes that had three consecutive substandard quality of care sanctions that did not have the mandatory denial of payment remedy enforced, or if there were nursing homes that were not in compliance 3 months after the last day of the survey.

The work was performed at the State Medicaid Agency in Tallahassee, Florida and the State Health Quality Assurance field office in Jacksonville, Florida. Additional fieldwork was performed from January to September 2003 at the various sanctioned nursing homes in Florida and at the Office of Inspector General, Office of Audit Services field offices in Jacksonville, Florida and Miami, Florida.

FINDINGS AND RECOMMENDATION

FINDINGS

Improper Medicaid Payments to Sanctioned Nursing Homes

The State permitted improper Medicaid payments for new admissions to sanctioned nursing homes. We found that 77 of the 100 sanctioned nursing homes received Medicaid payments while under the denial of payment sanction. Of the 77 sanctioned nursing homes, 31 received unallowable Medicaid payments for new admissions totaling $176,853 with $99,957 in Federal financial participation. In our opinion, these improper Medicaid payments occurred because the State did not have sufficient controls to ensure sanctioned nursing homes did not receive Medicaid payment. Therefore, the State controls were not adequate to prevent improper Medicaid payments to sanctioned nursing homes as required in Title XIX, section 1919 of the Social Security Act and 42 CFR § 488.

Controls to Ensure Sanctions Were Applied to Nursing Homes

State controls for ensuring the mandatory denial of payment remedy for substandard quality of care in nursing homes were applied correctly and were adequate. As a result, only 21 of the 547 nursing homes surveyed by the State (4 percent) warranted the denial of payment remedy based on the mandatory denial of payment for new Medicaid admissions requirements. The State was in substantial compliance with Medicaid participation requirements and did prescribe the denial of payment remedy as directed by law.

SANCTIONED NURSING HOMES

Federal Regulations

Title XIX, section 1919 of the Social Security Act established the requirements for nursing facilities, which are implemented by the State and the Secretary of HHS. Nursing facilities undergo an annual State survey and certification process to reveal whether a nursing facility is in substantial compliance with the Federal requirements. Substantial compliance means a level of compliance such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Deficiencies result from noncompliance or substandard quality of care in the nursing home. Facilities not in substantial compliance with these Federal standards of care are deficient and may have enforcement remedies imposed on them. Denial of payment sanctions may be imposed alone or in combination with other remedies when certification standards of care are not met.

42 CFR § 488 sets forth the regulations governing the survey, certification, and enforcement process. The remedies imposed on a nursing home result from the seriousness of the deficiency, which is measured by the severity and scope of the deficiency. Certification of noncompliance means that the nursing home is not eligible to participate in the Medicaid program. The State survey agency must re-certify the nursing home for substantial compliance before the

enforcement remedies are lifted. The denial of payment remedies are used for nursing facilities not in substantial compliance with one or more of the Medicaid participation requirements.

The denial of payment status of a resident is determined by the admission date. According to 42 CFR § 488.401, a new admission is defined as:

> . . . a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment.

CMS's *State Operations Manual* defines the two types of denial of payment remedies. The *State Operations Manual*, section 7506 establishes the denial of payment for new admissions for all new Medicaid residents, which is either an optional or mandatory sanction depending on the seriousness of the deficiency. CMS or the State may, and in certain instances, must, deny payment for all new Medicaid admissions when a facility is not in substantial compliance with the Medicaid participation requirements. The *State Operations Manual*, section 7508 requires HHS Secretarial approval and is the denial of all payments for all Medicaid residents. In instances of denial of all payments for all Medicaid residents, no payments are made for the period between the date the remedy was imposed and the date CMS verifies the facility is in substantial compliance with Federal requirements. CMS resumes payments to the facility prospectively once the facility achieves substantial compliance.

Medicaid Payments Received

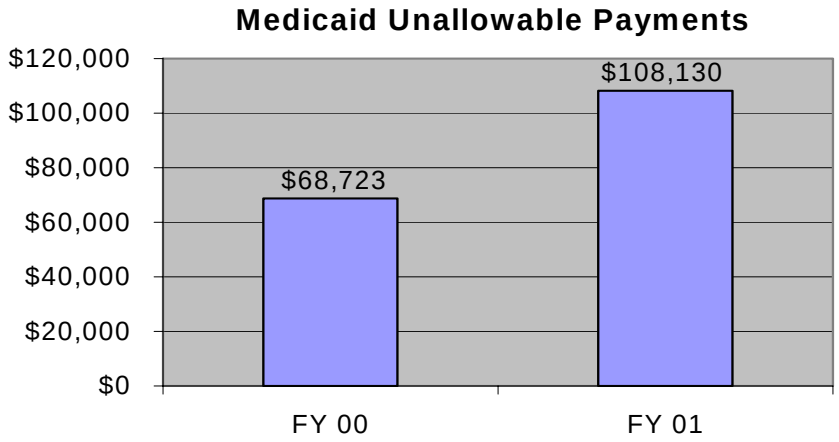
There were a total of 100 sanctioned nursing homes in the State. While under the denial of payment sanction, 77 nursing homes received Medicaid payments. Of the 77 sanctioned nursing homes, 31 received unallowable Medicaid payments for new admissions. There were no nursing homes that were denied all payments for all Medicaid residents.

Lack of Edits to Prevent Medicaid Payments

These improper Medicaid payments occurred because of the lack of controls between the State's Medicaid Agency and fiscal agent. The fiscal agent did not have edit checks in place to prevent Medicaid payments for sanctioned nursing homes.

Improper Medicaid Payments for New Admissions

The State made improper Medicaid payments for new admissions totaling $176,853 ($99,957 Federal share). See Appendix A for the detailed results of the unallowable Medicaid payments.



The chart illustrates the portion of improper Medicaid payments for new admissions during the sanction periods within our audit period in fiscal years 2000 through 2001.

CONTROLS TO ENSURE NURSING HOMES WERE SANCTIONED

Federal Regulations

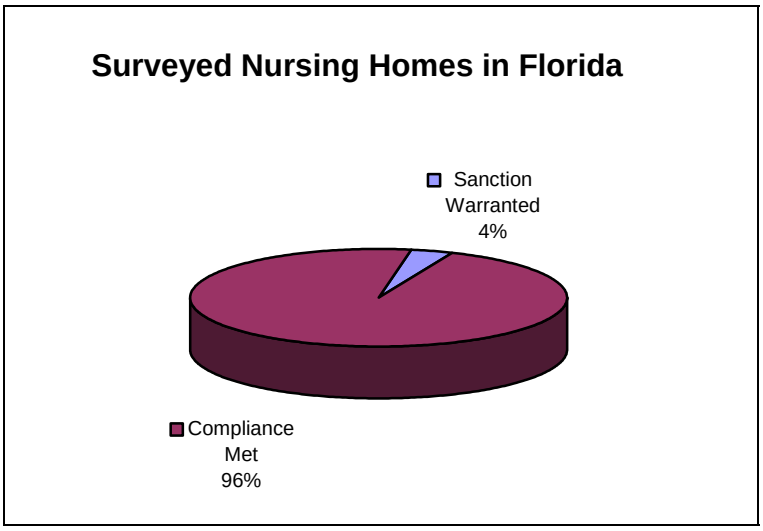
CMS's *State Operations Manual*, section 7001 defines ***substandard quality of care*** as:

> . . . one or more deficiencies related to participation requirements under 42 CFR 483.13, resident behavior and facility practices, 42 CFR 483.15, quality of life, or 42 CFR 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

CMS's *State Operations Manual*, Section 7506 (C) (2) states that the mandatory remedy must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying the deficiency, or when a facility has been found to have furnished substandard quality of care on the last three consecutive standard surveys. The State Medicaid agency must deny payment to the facility, and CMS must deny Federal financial participation to the State Medicaid agency for all new Medicaid admissions to the facility.

Denial of Payment Not Imposed

Of the 547 nursing homes surveyed by the State, we found only 21 (4 percent) that did not have a denial of payment remedy applied although it was warranted.



- **Compliance Met** is defined as all surveyed nursing homes with substantial compliance and all deficient nursing homes with remedies imposed.
- **Sanction Warranted** are nursing homes that should have the denial of payment remedy imposed, but weren't sanctioned.

The sanction warranted percentage is based on the actual number of nursing homes surveyed by the State that should have been sanctioned but weren't and subject to denial of payment or denial of payment for new admissions remedy. The compliance met percentage includes both sanctioned and certified nursing homes surveyed.

Adequate Controls in Place

We believe State controls were adequate to ensure the mandatory denial of payment remedy for substandard quality of care was applied in nursing homes that were not in compliance.

State Properly Applied Remedy

The State properly applied the remedy for sanctioning nursing homes that are out of compliance.

CONCLUSION

State controls were inadequate to prevent improper Medicaid payment to sanctioned nursing homes. Sanctions are imposed to safeguard beneficiaries. The denial of payment is an enforcement remedy for nursing facilities not in substantial compliance with one or more of the Medicaid participation requirements. The severity of the deficiency and level of harm to the resident requires imposition of the denial of payment remedies. It is imperative that the State suspends nursing home providers timely from the Medicaid program when there is risk to residents' health and/or safety.

RECOMMENDATIONS

We recommend that the State:

- refund to CMS $99,957 representing the Federal share of the $176,853 unallowable payments; and

- implement additional procedures to ensure payments to the provider(s) are suspended timely.

AUDITEE COMMENTS

Refund to CMS $99,957 (Federal Share) of $176,853 in Unallowable Payments

The State agreed that $135,394 of the $176,853 ($99,957 Federal share) recommended for adjustment was unallowable. The State has already collected or is in the process of collecting $88,994 of the overpayments. The State requested additional documentation to support the disallowance of $46,400 for which they had no record of a denial of payment for new admissions being issued.

The State did not agree that the remaining $41,459 was for unallowable payments. The State responded that the disallowed payments identified in the audit included $40,262 in payments for beneficiaries who were not new admissions and $1,197 for beneficiaries whose Medicaid applications were pending approval prior to the denial of payment for new admissions sanction.

Implement Additional Procedures

The State concurred with our procedural recommendations. While the State believes it is not feasible to develop a program in their paid claims system to suspend payments for new admissions during sanction, they have devised a recoupment process whereby the Agency's Bureau of Medicaid Program Integrity and Bureau of Medicaid Services will work together to research any inappropriate payments made to sanctioned nursing homes. In addition to this, the State plans to regularly send "banner messages" to all nursing facilities with instructions that they will recover any payments made to sanctioned nursing homes. The complete text of the State's comments is included as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to the State's request for documentation for the $46,400 unallowable Medicaid payments, we will provide the applicable CMS denial of payment for new admissions letters.

In regard to the $41,459 the State believes to be allowable, we disagree that the beneficiaries were not new admissions during sanction periods. Our finding is based on admission documentation obtained from the nursing homes.

CMS's *State Operations Manual*, section 7506 E describes the effect of remedy status of residents admitted, discharged, or on temporary leave and readmitted before or after effective date of denial of payment. One of these controlling factors specifically state:

> . . . Medicare and Medicaid residents who were admitted and discharged before the effective date of the denial of payment for new admissions are considered new admissions if they are readmitted on or after the effective date. Therefore, they are subject to the denial of payment remedy.

Therefore, we believe $99,957 represents the Federal Share of $176,853 in unallowable payments for new admissions to nursing homes during sanction periods.

APPENDICES

APPENDIX A

TOTAL MEDICAID UNALLOWABLE PAYMENTS

NURSING HOME	*SANCTION START*	*SANCTION END*	*RESIDENT COUNT*	*SANCTION DAYS*	*TOTAL*
1	12/09/1999	12/20/1999	2	16	$ 1,736.96
2	08/24/2001	12/17/2001	3	190	19,868.29
3	10/19/2000	12/25/2000	1	4	415.32
6	09/27/2000	11/28/2000	5	96	8,971.88
7	02/02/2001	02/21/2001	1	30	3,937.50
8	05/29/2000	06/18/2000	5	70	8,411.90
9	08/03/2000	09/07/2000	2	36	4,259.26
10	04/11/2001	04/18/2001	1	7	793.10
19	07/23/2000	10/15/2000	2	92	7,887.47
22	01/20/2000	01/24/2000	1	4	302.00
23	10/12/2000	10/31/2000	3	18	2,995.67
24	12/19/2000	01/07/2001	2	9	949.75
25	06/28/2000	08/23/2000	1	46	4,462.00
28	06/29/2000	07/24/2000	1	19	1,547.58
30	08/17/2000	09/18/2000	8	98	9,406.40
34	05/28/2001	06/03/2001	2	9	987.39
42	08/29/2000	10/30/2000	1	59	5,184.50
47	11/08/2000	11/08/2000	1	1	109.00
51	07/26/2001	07/30/2001	2	9	1,052.17
52	08/15/2001	09/12/2001	4	71	6,273.78
54	07/20/2000	09/13/2000	6	164	16,552.69
55	07/27/2001	07/29/2001	1	1	110.37
56	08/17/2001	09/20/2001	5	45	4,835.40
57	04/06/2001	05/07/2001	5	104	12,427.85
58	12/28/2000	01/21/2001	4	70	7,409.92
61	06/13/2001	07/01/2001	6	37	4,983.85
63	10/01/2000	11/01/2000	5	49	4,459.15
65	01/05/2001	01/10/2001	1	4	337.55
70	03/08/2001	04/22/2001	5	133	15,443.39
72	03/07/2001	05/23/2001	7	177	18,219.51
74	08/04/2001	09/04/2001	2	25	2,521.42
31			95	1,693	$176,853.02

TOTAL UNALLOWABLE MEDICAID PAYMENTS	**$176,853**
TOTAL SANCTIONED NURSING HOMES	**31**
TOTAL RESIDENT COUNT	**95**
TOTAL SANCTION DAYS	**1,693**

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

January 5, 2004

Mr. Charles J. Curtis
Office of the Inspector General
Office of Audit Services – Region IV
61 Forsyth Street, Southwest, Suite 3T41
Atlanta, GA 30303

RE: CIN A-04-03-06007

Dear Mr. Curtis:

Thank you for the opportunity to respond to the U.S. Department of Health and Human Services Office of the Inspector General, draft report *Nursing Homes and Denial of Payment Remedies in the State of Florida,* dated November 14, 2003. Please accept my apology for the delay in issuing this response, which had a deadline of December 14. We have notified the auditors assigned to this project of the delay.

Each of the report recommendations and the Agency's response follows:

We recommend that the State:

- *Refund to the Centers for Medicare & Medicaid Services (CMS) $122,416 representing the Federal share of the unallowable payments.*

Agency Response:
The HHS/OIG auditors, upon request, provided to the Agency's Bureau of Medicaid Program Integrity (MPI) a detailed list of the unallowable payments resulting from denial of payment for new admissions (DPNA) sanctions. The list provided by the HHS/OIG auditors has been updated to indicate the status of each payment and to summarize the payments by status. The updated list has been returned to the auditors.

MPI's research revealed that of the $296,592.17 comprising the total amount of payments included in the HHS/OIG list, $81,194.73 was for claims that are allowed pursuant to federal regulations, leaving $135,397.44 in actual unallowable payments. Of this amount, $88,993.64 either has been or is in the process of being recouped using the Agency's ongoing recoupment process (explained below.) For the remaining $46,403.80, the Agency has no record of the DPNA being levied by CMS and has requested supporting documentation from the HHS/OIG auditors. Once the Agency receives this documented evidence of the unallowable payment, we will pursue recoupment and reimbursement to CMS.

- *Implement additional procedures to ensure payments to the provider(s) are suspended timely.*

Agency Response:

Certain nursing home admissions, such as readmissions and recipients who had applied for Medicaid prior to the sanction period, are authorized for payment during the sanction period. In many instances the CMS notice of sanction effective date is not received until after the sanction period has begun or has past. This is especially common when the duration of the imposed sanction is short, such as only a day or two. Also, the Agency does not consistently receive notice from CMS when the sanction period has ended.

For these reasons, it is not feasible to program the Florida Medicaid Management Information System to suspend payments for new admissions during sanction periods. Thus, our process is to, upon notification of a DPNA effective date from CMS, determine if payments were made for new admissions, research whether the payment should be allowed, and pursue recoupment where appropriate.

To support the recoupment efforts of MPI, staff within the Agency's Bureau of Medicaid Services will devise a "tickler file" based upon receipt of the CMS notice of DPNA. Procedures will be implemented to coordinate with MPI in researching payment histories of the sanctioned facilities.

Finally, in addition to our ongoing recoupment process, the Agency is currently amending the Nursing Facility Coverage and Limitation Handbook. We will add additional language to the existing text to emphasize that facilities are not to seek reimbursement for new admissions during the DPNA sanction period. Further we will utilize our system of "banner messages" to regularly remind facilities that payments made during the sanction period will be recovered.

If you have any questions regarding this response, please contact Judy Hefren at (850) 921-4897 or Kathy Donald at (850) 922-8448.

Sincerely,

Rhonda M. Medows, MD
Secretary

RMM/kd

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